NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NRHM Newsletter

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Innovative Public-Private Partnerships in Maternal Health

Role of ANMs in NRHM

Progress under NRHM

ASHAs/Link Workers

- 628831 ASHAs/Link Workers Selected.
- 548161 ASHAs & link workers given orientation training out of which 243133 ASHAs have been positioned with kits.

Institutional Delivery

- Janani Suraksha Yojana (JSY) operationalised in all the States and received tremendous response. Against 29.30 lakh women benefited in 2006-07, the number of beneficiaries jumped to 72.95 lakh in 2007-08.

Monthly H&N Days in Anganwadi

- Over 44.76 lakh Monthly Health and Nurtrition Days have been organized at the Anganwadi Centres in various states during 2007-08.

Neo Natal Care

- Integrated Management of Neonatal and Childhood Illnesses (IMNCI) started in 193 districts this year.
- With the help of Neonatology Forum over 71355 health care personnel trained in Newborn Care in the country.
- Module for Home based new born care developed in consultation with Dr. Abay Bhang. ASHAs to be trained in Home based new born care shortly especially in the States of UP, Bihar, Orissa, Rajasthan and Madhya Pradesh.

Immunization

- JE vaccination completed in 36 districts in 8 states 16.48 million children immunized during 2006-07. Vaccination is going on in 2 districts of Bihar since Dec,2007. The 11 districts of 4 states where JE vaccination was carried out in 2006 have introduced JE vaccine in Routine Immunization to vaccinate new cohort between 1-2 years of age with booster dose of DPT.
- Neonatal Tetanus declared eliminated from 7 states in the country.
- Full immunization coverage evaluated at 43.5% at the national level.(NFHS-III) Accelerated Immunization Programme taken up for EAG and NE States.

Village Health & Sanitation Committees

- 297794 Village Health and Sanitation Committees have been constituted by the States. They are being involved in dealing with disease outbreak.

Rogi Kalyan Samitis

- Over 22,399 Rogi Kalyan Samitis set up in various health centers and hospitals.

Infrastructure

- All Subcentres in the country (1,46,000) provided with untied funds of Rs. 10,000 each. Joint accounts of ANMs and Pradhans have been opened for utilization of annual untied funds of Rs.10000/. 130812 subcentres have been positioned with at least one ANM.
- Out of 4045, 2870 CHCs have been selected for upgradation to IPHS and facility Survey been completed in 2635.

Manpower

- 12720 Doctors and specialist, 32321 ANMs, 17979 Staff nurses, 7590 paramedics have been appointed on contract by States to fill in critical gaps.

Management Support

- 1265 professionals (CA/MBA/MCA) have been appointed in the State, 523 District level Program Management Units (PMU) and 2883 blocks to support NRHM.

Mobile Medical Units

- Funds for one Mobile Medical Unit (MMU) per district released for 318 districts. The states have, till date operationalised 212 Mobile Medical Units with their own funds.
- Convergence with ICDS/Drinking Water/Sanitation/NACO/PRIs ground work completed.
- School health programmes initiated by 26 States.

Health Action Plans

- State PIP received from 31 states during 2006-07, 35 states PIP received during 2007-08 and 35 states during 2008-09. Project Implementation Plan (PIPs) of the States under NRHM have been appraised and funds are being released for the year 2007-08.
- Integrated District Health Action Plans (DHAP) have been finalized for 558 districts.

Mainstreaming of AYUSH

- Mainstreaming of AYUSH taken up in the States. AYUSH practitioners co-located in 3514 PHCs. AYUSH part of State Health Mission/Society as members.

Trainings

- Trainings in critical areas including Anaesthesia, Skilled Birth Attendance (SBA) taken up for MOs/ANMs. Integrated Skill Development Training for ANMs/ LMV/MOs, Training on Emergency Obstetrics care and No Scalpel Vasectomy (NSV) for MOs, Professional Development Programme for CMOs are on full swing.

Mother NGOs

- 351 Mother NGOs appointed for 346 districts till date are fully involved in ASHA training and other activities.

Health Resource Centres

- National Health Systems Resource Centre (NHSRC) set up at the National level.
- Regional Resource Centre set up for NE.
- State Resource Centre being set up by States.

Monitoring and Evaluation

- Independent evaluation of ASHAs/JSY by UNFPA/UNICEF/GTZ in 8 States.
- Immunization coverage evaluated by UNICEF.
- Independent monitoring by identified institutions like Institute of Public Auditors of India.
- Ground work for community monitoring completed.

Financial Management

- Financial Management Group set up under NRHM in the Ministry.

NRHM has boosted immunization coverage

Innovative Public- Private Partnerships for Maternal Health

The NRHM has facilitated innovative Public- Private Partnerships for Maternal Health with various stakeholders. These interventions strive for enhancing availability of facilities and access for institutional deliveries and emergency obstetric care. These partnerships include programmes like Chiranjeevi Yojana and Voucher Scheme vide which women have easy access with financial benefits to safe, institutional delivery. Other schemes like Ambulance Services increase access to maternal health services by strengthening referral transport system.

One of the key objectives of the National Rural Health Mission is to improve availability and access of quality health care to the poor, especially women and children. With reduction in maternal mortality being an important goal under RCH -II, a number of innovative interventions have been initiated to increase accessibility of health care to the poor and rural population.

To reach out to the vulnerable sections of the rural poor including women and children in remote areas spread across the country, public- private partnership models have been activated to enable women to have access to institutional deliveries. Some innovations are based on demand side financing through vouchers while other innovations focus on contracting out institutional delivery to the private sector. A few states have created additional facilities like maternal homes to enhance geographical access.

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Chiranjeevi Yojana and other schemes

Chiranjeevi Yojana is a unique public-private partnership initiative to enable pregnant women access safe institutional delivery. The scheme which is being implemented in all 25 districts of Gujarat negotiates partnerships with the private sector to provide access to institutional deliveries for women living below the poverty line. The main feature of this Yojana is the contracting of private gynecologists for normal and complicated deliveries at their health facilities along with provisions for transport.

The scheme provides financial incentives to private providers to offer qualitative obstetric services. These private clinics/hospitals are selected on the basis of set norms and are contracted for providing services at the district level through a fixed pricing mechanism. The contract with each provider is for a maximum of 100 deliveries at a cost of Rs 179,500. This includes the cost for both normal and complicated deliveries and also takes care of the transport cost of the patient along with an incentive of Rs 50 for the person who is accompanying the pregnant woman.

The district health officer selects the private providers as per the defined norms and coordinates the various activities under this scheme. The norms are clearly defined from district to the village level.

The Chiranjeevi Yojana which was initially started as a pilot project in five low performing districts of Gujarat has now been scaled up to all the districts and has been a success story in reaching out to poor women living in rural and inaccessible areas. Studies done by international agencies point out that institutional deliveries have increased to a great extent and private providers have shown willingness to get involved in this form of demand side financing.

"The Chiranjeevi Yojana which was initially started as a pilot project in five low performing districts of Gujarat has now been scaled up to all the districts and has been a success story."

A similar Yojana is also being implemented in the state of Assam where services are contracted out to private doctors and hospitals. The scheme also provides insurance cover to all pregnant women living below the poverty line. Many similar schemes have been started by various state governments. Notable among these is the Ayushmati scheme which is operational in 11 districts of West Bengal. This private public partnership initiative works towards enhancing access and improving institutional deliveries. The Saubhagyawati scheme, being implemented in Uttar Pradesh, caters to below poverty line population in urban and rural areas where a private agency provides a range of services from antenatal care to prenatal care, neonatal care and family planning. The agency is selected to cover one or more blocks. Empanelment of Gynaecologists/Hospitals is being done by medical officers in charge of Block PHCs.

Voucher Scheme for institutional delivery

This is an innovative scheme through which women below the poverty line are provided with vouchers which entitle them to free maternal health care package, thereby also motivating the private sector to reach out to these women and provide them safe delivery options. The basic objective behind this exercise is to increase demand and service coverage for a predetermined RCH service package. The voucher system is managed through a network of stakeholders including NGOs, the district health system and private providers. The scheme is currently operational in certain areas of Uttar Pradesh and Uttrakhand.

The voucher scheme provides for three antenatal check up (ANC) visits which includes TT injection, IFA tablets, counseling and institutional delivery both normal and caesarian. It also includes two post natal visits, family planning services, child immunization, RTI/STI check up/ treatment, partner counseling and diagnostic tests.

The focal point of this unique scheme is the ASHA who disseminates information about this voucher scheme to the community. They also identify and register

the pregnant women in their village, plan for their appropriate health services, distribute vouchers which are serially numbered, arrange for transport facilities, accompany these woman to health care centers, provide feedback and maintain records.

A Voucher Management Agency (VMA) which functions under the project advisory committee chaired by the district magistrate or the chief medical officer is responsible for the overall management of the scheme including identification and accreditation of the private nursing homes involved in the project. The VMA also conducts training programmes for staff of the accredited institutes on all aspects of the project and carries out monitoring and evaluation activities.

Many states are adopting similar voucher schemes for promoting institutional delivery. The Janani Suvidha Yojana which is functional in the state of Haryana is modeled on a similar pattern. The aim is to increase access to safe and institutional delivery for BPL women through private health providers and referral arrangements. Madhya Pradesh is also implementing a similar scheme called Janani Sahyogi Yojana. Under this scheme, accredited private health facilities for MCH services are reimbursed on a fixed price basis.

“One of the major causes of Maternal Mortality is the delay faced by women in accessing medical care often due to lack of affordable transport facilities. Establishing referral linkages between the community and First Referral Units (FRUs) is one of the most important tasks for utilization of available services during emergencies.”

Referral linkages for obstetric emergencies

One of the major causes of Maternal Mortality is the delay faced by women in accessing medical care often due to lack of affordable transport facilities. Establishing referral linkages between the community and First Referral Units (FRUs) is one of the most important tasks for utilization of available services during emergencies. A key intervention of NRHM has been to bridge this gap and make available affordable transport facilities to poor women residing in inaccessible areas and where availability of transport are poor and erratic.

One of the major challenges faced in providing this service is making it accessible to the marginalized sections of society. Apart from the contractual and administrative challenges, the authorities find it difficult to make the public aware of this facility and ensure a state of preparedness at the health facility where the woman is transported for quality maternal care.

Many states have come up with their own initiatives to address this issue.

Janani Express Yojana, Madhya Pradesh

This is a unique scheme under Public- Private Partnership where the district health authority contracts emergency transport services for obstetric services and other medical emergencies to private vehicle owners with the objective of increasing access to institutional care.

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Under this scheme a vehicle is expected to be stationed round the clock at a block level facility accessible to women in case of delivery and pregnancy related complications. The operational costs are fixed and the facilities can be availed free of cost by women living below the poverty line. The scheme has been very successful and is being scaled up to become functional in 204 of the 313 blocks in the state of Madhya Pradesh.

Ambulance Scheme, West Bengal

The key objective of this scheme is to provide cost effective ambulance facility round the clock for obstetric and other medical emergencies through a fleet of ambulances outsourced to NGOs. Under this scheme, the district health societies in West Bengal have inked a five year agreement with NGOs where ambulances are made available at the block primary health centers or rural hospitals for round the clock service . The NGOs are responsible for maintenance and operational costs. Each one of these ambulances has a trained attendant and a driver with mobile phones to respond to emergencies. This facility is operational in all the districts of West Bengal.

Obstetric Helplines, various states

A number of states like Rajasthan, Bihar, Mizoram and Andhra Pradesh have initiated for providing transport facilities through toll free helpline numbers. The operation and management of these schemes has been entrusted to NGOs.

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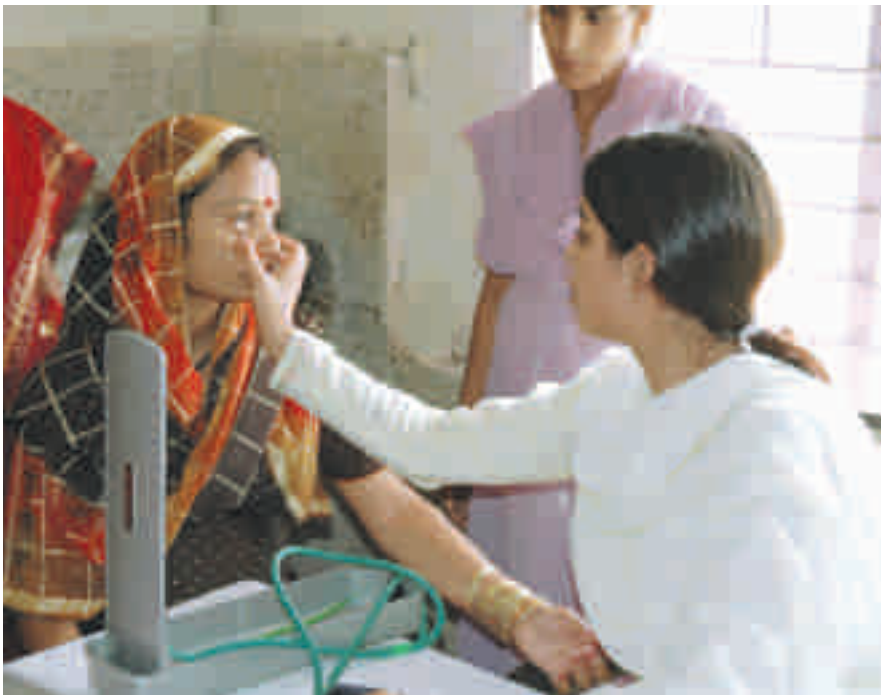
Capacity Building of Service Providers

One of the major constraints in providing quality obstetric care to the community has been the non-availability of skilled professionals locally. The NRHM has brought in various modifications in Govt. policies to enable and provide multi skill training for selective interventions under specific emergency situations to prevent maternal deaths.



Non specialist care providers like MBBS doctors are being trained in Emergency Obstetric care (EmOC) and life saving anesthetic skills to overcome this acute shortage of specialists at the level of First Referral Units (FRUs).

The Government of India has awarded a grant to FOGSI to build capacity of selected state medical colleges to work as nodal training centers for enhancing capacities of MBBS medical doctors in emergency obstetric care. The EQUIP (Enhancing Quality Care in Public Health Care) programme which is operational in 64 selected blocks of Chhattisgarh is an example of such initiative.

The EQUIP Initiative

The Equip initiative is a unique experiment that focuses on block level planning by closing gaps that exist in the system, especially that of non availability of trained professionals. The key objective of this initiative is to address the issue of service delivery by building capacities of service providers at various levels concerning safe motherhood.

"The Village Health and Nutrition day which is organized once in every month in the villages is an innovative experiment in making the community aware of various facets of maternal and child care. The whole idea behind this exercise is to sensitise the community about maternal and child care issues and inform them about the various facilities and schemes that are available and encourage them to avail these facilities. In fact VHND is one of the major sources of interface between the community and the health system."

The emphasis is to make every Community Health Centre (CHC) and the First Referral Units (FRUs) capable of delivering quality emergency obstetric care, every Primary Health Centre open round the clock to conduct institutional deliveries, and every Sub health center equipped to provide antenatal care.

The strategies followed to achieve these objectives include developing micro plans in the selected blocks to identify gaps in infrastructure, ensuring availability of equipment and supplies and taking effective steps to address such issues. Equal importance is also given in multiskilling of the available workforce to operate the facilities and new appointments are facilitated to fill the gaps.

The project which was initiated in the year 2003 has successfully trained over 52 candidates in emergency obstetric anesthesia and comprehensive emergency obstetric care.

Certification of facilities for CEmONC

This initiative which is operational in the state of Tamil Nadu provides certification of facilities for comprehensive emergency obstetric and newborn care. The certifications are based on a set of accreditation criteria with focus on quality of care which is monitored by specialists. The certification is evaluated on the basis of casualty services, EmOC procedures, newborn care, laboratory services, post operative care, adherence to standard emergency treatment protocol and quality of provider - patient interaction.

Village Health & Nutrition Day

The Village Health and Nutrition day which is organized once in every month in the villages is an innovative experiment in making the community aware of various facets of maternal and child care. The whole idea behind this exercise is to sensitise the community about maternal and child care issues and inform them about the various facilities and schemes that are available and encourage them to avail these facilities. In fact VHND is one of the major sources of interface between the community and the health system.

The VHNDs are usually organized at the Anganwadi centres on Thursdays. On the appointed day, the village health and sanitation committee members comprising of ASHA, Anganwadi worker, ANM, Panchayat members and health personnels assemble at the Anganwadi centre and freely mingle with the community, informing and sensitizing them of the preventive and promotive aspects of health care. Posters, banners and other IEC materials are used to attract the villagers to the camp.

The major activities at the camp include registration of pregnant women, vaccination of children, distribution of contraceptives, administration of anti-TB drugs and checking of children for malnutrition. Apart from these activities, members of the community, especially women, are provided extensive counseling on nutrition, pregnancy, breast feeding, prevention of malaria, TB and other communicable diseases, prevention of STDs, HIV/AIDS, sanitation and safe drinking water. All the members including ASHA, AWW, ANM and PRIs are provided with checklists to ensure proper planning and smooth delivery of services to the community.

The VHND is a unique way of reaching out to the community at their doorstep with health services.

Role of ANMs in NRHM

By Geeta Malik

> "Total contractual ANMs recruited for all levels including sub-centres are 32,321 (as on 30.8.2008). There has also been a significant increase in number of ANMs/MPW(F) at SC and PHCs between September 2005 (1,33,194) to March 2007 (1,47,439)."

In India, public health nursing in the villages today is still limited to the services rendered by Multipurpose Health Worker (Feamle) {MPHW(F)}or Auxiliary Nurse Midwife (ANM). ANMs are regarded as the first skilled contact person between people and organization, between needs and services and between consumer and provider. It is through their activities that people perceive health policies and strategies. It is through them that planners at the upper level gain insights into health problems and needs of the rural people. Considering their status as grassroots level workers in the health organizational hierarchy, a heavy responsibility rests on them. Their services are considered essential to provide safe and effective care and as a vital resource to achieve the health related targets. The present concern in the country is to provide accessible, affordable, accountable, equitable, effective and reliable health care, especially to poor and vulnerable sections of population in rural areas. It is, therefore, interesting to analyse the role being played by ANMs in providing health care services to people in the changing context of National Rural Health Mission (NRHM).

Background

The role of ANMs has been changing with times. In the '50s and '60s, training courses for ANMs focused on mid-wifery and Maternal and Child Health (MCH) as 9 months out of 24 months, were earmarked for these subjects. India's Second Five Year Plan described the role of auxiliary health workers as those activities that supplemented the contributions made by doctors and other highly trained personnel for promoting preventive and curative health activities (GOI, 1956). Mukherjee Committee (1966) recommended a system of targets and incentives and identified ANMs and other village level workers as agents for the popularization of the programme. In 1973, the Government of India (GoI) integrated the various functions of the health services and thereby changing the role of ANMs (Kartar Singh Committee). In 1975, Srivastava Committee called for an expansion of their training to prepare them for multipurpose health work. ANMs were now required to provide child health services and primary curative care to villagers. In turn, the Indian Nursing Council (INC) approved an expanded syllabus in 1977. With this came the decision to reduce the training period from 24

NRHM has boosted immunization coverage

months to 18 months. The National Education Policy (1986) included the ANM programme under the stream of Vocational Education. The INC again reviewed the curriculum for the +2 level and submitted its recommendations to the Ministry of Health and Family Welfare. However, only a few states have adopted this course at the higher secondary level as a vocational course.

Key Workers

National Rural Health Mission, launched on 12th April, 2005, to enhance comprehensive primary health care services especially for the poor and vulnerable sections of the society, continues to realize the ANMs as key workers at the interface of health services and the community.

The Mission seeks to provide minimum two ANMs (against one at present) at each Sub-Centre, as it has been found that one ANM at a sub-centre is not adequate to attend to the complete needs of maternal and child care in any village. The Government of India (GoI) would support the second ANM for appointment on contract basis and apart from fulfilling the other criteria she must be a resident of a village falling under the jurisdiction of the sub-centre. The intention is to improve accountability at the local level. The second ANM would not be transferred before completion of ten years at the same sub-centre and would not be a substitute for Male Health Worker (MHW). An untied fund of Rs.10,000/- per sub-centre per annum is being provided by opening a joint account of the ANM and Sarpanch, to meet the emergency type expenditures and to ensure that lack of drugs and other consumables is not an issue. 1,32,279 sub-centres have opened such joint accounts.

There are significant achievements in certain areas with the active support of State Governments. Total contractual ANMs recruited for all levels including sub-centres are 32,321 (as on 30.8.2008). There has also been a significant increase in number of ANMs/MPW(F) at SC and PHCs between September 2005 (1,33,194) to March 2007 (1,47,439). By engagement of contractual ANMs, wherever required, and by provision of Rs. 10,000 annual untied grant, nearly all 1,46,026 Sub Health Centres have been made functional. Sub-centres have judiciously used the united funds as per need, from buying B.P. Equipment, weighing machine, to repairing the Examination Table, cleaning the Sub Centre, etc. Early evidence suggests that deliveries have started taking place in a few Sub Centres because of the untied grants. Also ANMs/ASHAs/AWWs have been the main source of information about Janani Suraksha Yojana (JSY).

The ANM being the member secretary of Village Health & Sanitation Committee, has to organisel regular meetings of the Committee, prepare the Village Health Plan depending on the needs of the community. One of her most important job responsibilities is to organise the Village Health & Nutrition Day at the village. This is to facililitate on a single day at the same place various services such as Immunization, distribution of IFA tablets, Vitamin A, Nutrition, Deworming, well-baby clinic, family planning counselling - along with Anganwadi worker and ASHAs.

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As part of her job responsibilities, ANM has to provide for services in Maternal health, Child health and Family Planning services; Nutrition, Health education, treatment of minor ailments and first aid in emergencies and disasters, collaborative service for improvement of enviornmental sanitation etc.

The Government of India has been funding the salary of ANM and LHV to the States. The salary of Male Health Worker is borne by the States but nearly 50% of the existing sub-centres do not have a MHW. This has also some bearing on the workload of the ANMs in position.

In addition to these duties, the ANM would perform the following functions in guiding and training the female 'Accredited Social Health Activist' (ASHA), as envisaged in the Guidelines on ASHA, under NRHM:

- Holding weekly/fortnightly meeting with ASHA to discuss the activities undertaken during the week/fortnight.
- Acting as a resource person, alongwith Anganwadi Worker (AWW), for the training of ASHA.
- Informing ASHA about date and time of the outreach session and also guiding her to bring the beneficiary to the outreach session.
- Participating and guiding in organizing the Health Days at Anganwadi Centre.
- Taking help of ASHA in updating eligible couple register of the village concerned.
- Utilizing ASHA in motivating the pregnant women for coming to sub-centre for initial checkups.
- ASHA helps ANMs in bringing married couples to sub-centres for adopting family planning.
- Guiding ASHA in motivating pregnant women for taking full course of Iron Folic Acid (IFA) Tablets and TT injections, etc.
- Orienting ASHA on the dose schedule and side affects of oral pills.
- Educating ASHA on danger signs of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.
- Informing ASHA on date, time and place for initial and periodic training schedule. ANM would also ensure that during the training ASHA gets the compensation for performance and also TA/DA for attending the training.

ANM is expected to get information from ASHAs regarding the progress made and consolidate the report at PHC level. ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat. She will receive performance-based compensation for promoting universal immunization, referral and escort services for RCH, and other health care delivery programs. Against all ASHAs to be selected and 3 lakh of them to be given drug kits by 2008, 5,36,057 ASHAs have already been trained (out of 6,31,855 selected) and 2,24,971 ASHAs have been positioned with kits to commence community level health initiatives.

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Conclusion

NRHM provides that the ANMs will have the support of 4-5 ASHA and the Anganwadi Workers (AWWs) in discharging her duties and the role envisaged in the Mission. It is, therefore, expected that they will be able to devote more time to render clinical services to the population and contribute in achieving the goals of the Mission to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance.

How to take care of a sick person

Excerpts from the Indian adaptation of ***Where There is No Doctor***, recently brought out by the Ministry of Health & Family Welfare, Govt. of India, for the use of field Health workers.

To find out the needs of a sick person, first you must ask important questions (taking the history) and then examine him carefully. (physical examination) Look for signs that will tell you what sickness he may have and how ill he is. Often, a good history and physical examination gives you the correct diagnosis. There are certain basic things to ask and to look for in anyone who is sick. The things that the sick person feels are called symptoms, and the things that you see or notice during examination are called signs. These signs are especially important in babies and persons who are not able to talk. Before you ask questions and examine the person, make sure that :

A. he/she is comfortable.

b. you ask questions and make your examination as private as possible, like doing your examination in a room or using a cloth to cover him or her during examination.

c. you focus the discussion on the problem and continue in an orderly manner.

d. you make and keep a record of the sick person; this will be of help later if the person comes back for another treatment or advice or if it is necessary to send him to the doctor.

e. you examine the person where there is good light, preferably in the sunlight.

f. in emergency cases like bleeding, shock or convulsion, you treat first and then ask questions later. If you need to know anything, ask only the very important questions.

g. when examining infants and children, you must remove all their clothes.

h. when the sick person cannot remember the exact date of the start of his illness, you can refer to important events to give you an idea. For example : did the illness start before, during or after holidays, or was it Christmas or any festival time when his illness started ?

Taking the history not only includes the sick person's complaint and the story of his illness but also other information which may contribute to the development of his present illness. An outline for history taking and physical examination has been made to serve as your guide; however, you can make one according to your need.

General Information :

These information will let you know more about the sick person and will give you an idea about his illness. Write the date of examination, person's name, address, age, sex, whether he is married, single, widow, separated, his occupation, and religion. These information can give you an idea about a person's illness. Some diseases are common in certain age and sex groups, and some religious practices may also influence the development of an illness. A

person's occupation can give you an idea about his illness, e.g., a farmer who develops skin eruptions after using a fertilizer may be allergic to it. As you go on with your questions and examinations, you will be able to know more about his illness.

The main Problem :

This is the problem that bothers the sick person most and is the reason why he came to see you. He may have more than one problem or complaint. Try to find out the most serious among them and consider it as the main problem. Write the words exactly as he told you. Do not try to interpret his words with your own idea. A sick person who has cough, headache, fever, lack of appetite for about one month but is not bothered about it suddenly coughed out blood and immediately came to see you. His main problem is the coughing out blood, not his headache or cough.

The Story of His Present Illness :

Ask the sick person to tell you when his illness started and how it started. Trace as far back as possible, when he first experienced his illness. When he has finished, you can ask more questions to find out some more information about his sickness.

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If he complains of pain, ask him :

1. Where is the pain ? Tell him to point to you the exact place with one finger. Does the pain spread ? If yes, where ?
2. What is the pain like ? Is it sharp, dull, burning, heavy, steady, cramping ?
3. How bad is it ? Does it wake him up ?
4. How often does it come ? Does he feel the pain every day ?
5. How long does the pain last ? Does it last for 30 minutes, one hour, the whole day ?
6. When does the pain occur ? During exercise, running, walking, or after eating ?
7. What makes his condition better ? Rest, sleeping on one side ? What other things does he do to lessen the pain ?
8. What makes the condition worse ? Does the pain get worse when he coughs, eats or walks ?
9. What medicines did he take during the illness - either home remedies or borrowed from the neighbor or relatives ? How often does he take it, for how many days ? Did it make him better or worse ?
10. What other signs did he notice ? Weight loss, lack of appetite, problems in passing out urine, any changes in bowel habits, etc.

If the person complains of breathing problems, ask him the following questions:

- Any chest pain ? If the chest pain becomes worse by breathing or coughing and if the pain gets better by lying on the side, it means the beginning stages of pneumonia.
- If the chest pain comes on during walking, running, climbing up the stairs, and disappears on taking rest for a few minutes, it may mean heart disease.

If the person has cough, ask him if it keeps him from sleeping. Find out if he coughs up mucus, how much, its colour and if there is blood in it.

- Dry early morning cough is mostly due to too much smoking.
- Cough with large amounts of mucus which is white in colour (Bronchiectasis or chronic bronchitis .
- Cough with blood stained mucus, fever in the afternoon, and weight loss. If the sick person is above 40 years old and smokes too much, he could have cancer of the lungs.

If there is a lump, ask the following questions :

- When was the first time you noticed the lump ?
- How big was it when you noticed it (compare to other things like marble, grain of corn) ?
- What else did you notice about the lump (soft, hard, painful, hot, cold) ?

EXAMINING THE SICK PERSON : General Condition of Health

In examining the sick person, use your eyes, hands, ears and sense of smell. Before touching the sick person, look at his general health condition. Observe how ill or weak he looks, the way he moves, how he breathes and how clear his mind seems. Look for signs of dehydration.

"In examining the sick person, use your eyes, hands, ears and sense of smell. Before touching the sick person, look at his general health condition. Observe how ill or weak he looks, the way he moves, how he breathes and how clear his mind seems. Look for signs of dehydration."

Notice whether the person looks well nourished or poorly nourished. Has he been losing weight ? When a person has lost weight slowly over a long period of time, he may have a chronic illness (one that lasts a long time).

Also note the color of the skin and eyes. These sometimes change when a person is sick. (Look at parts of the body where the skin is pale, such as palms of the hands or sole of the feet, the finger nails, or the insides of the lips and eyelids).

- Paleness, especially of the lips and inside the eyelids, is a sign of anemia.
- Skin may also go lighter as a result of tuberculosis, or Malnutrition.
- Darkness of skin may be a sign of starvation.
- Bluish skin, especially blueness or darkness of the lips and fingernails, may mean serious problems with breathing or with the heart. Blue-gray color in an unconscious child may be a sign of cerebral malaria.
- A grayish-white coloring, with cool, moist skin, often means a person is in shock.
- Yellow color (***Jaundice***) of the skin and eyes may result from disease in the liver, (hepatitis or cirrhosis or amebic abscess or gallbladder. It may also occur in new born babies.
- Look also at the skin when a light is shining across it from one side. This can show the earliest sign of measles rash on the face of a feverish child.

Taking the vital signs :

Vital signs are things which you observe and measure in a sick person. They will tell you how ill he is and whether his condition is improving or not.

They are:

- Temperature
- Breathing (respiration)
- Pulse (heartbeat)
- Blood pressure

Letters

Dear Sir,

I am working as a Health Worker in a remote area of West Bengal. I have read your NRHM Newsletter. Kindly enlist our name in your mailing list

Ms. Nasima Begam,
Health Worker (Female),
Bansanka Health Sub-Centre,
P.O. Bansanka, Distt. Birbhum
West Bengal 731 125

Dear Sir,

I have read your NRHM Newsletter. I found it useful and informative. I am working as a Medical Officer and my wife is running an NGO especially for the development of women and child health. Kindly include my name in the mailing list for sending NRHM Newsletter regularly.

DR. Sanjay Kumar Divakar Shiwankar,
Medical Officer,
Sai Mandir Road Vidhya Nagar,
Bramhapuri, District, Chandrapur - 441206
Maharashtra

Dear Sir,

I am working as a Ayush Medical Officer at PHC, Kuppeluru and I have joint recently to this post. I read NRHM Newsletter regularly at PHC. It is very useful source to know all the Health programmes in India. Kindly put me in your mailing list and also send all the previous issues to know more about NRHM.

Dr. Anil Kumar Daginder BAMS,
(Ayush Medical Officer),
C/o Sri K.M. Swadi, "Malatesh Nilaya",
Shivayogeshwar Nagar, 2nd Cross,
Post Haveri 581 114
Tq./Dt. Haveri, Karnataka.

Dear Sir,

I found the issue of NRHM Newsletter Vol. 3 No.3 Sept-Oct very interesting and useful to the faculty and student community. I would be very happy and thankful to you if you include me in the mailing list and send me this newsletter.

Dr. K. Vijaya, MD,
Associate Professor of Community Medicine,
Konaseema Institute of Medical Sciences,
Chaitanya Nagar, NH 214,
Amalapuram 533 201
East Godavari Distt.
Andhra Pradesh.

Dear Sir,

I recently read your Newsletter and found it very informative. I am a junior Health Inspector. I have been organizing Health Camps of IEC activities in many places. I would like to get the English version of NRHM Newsletter on regular basis. Kindly enroll me in your mailing list.

Shri P. Ravindran,
Junior Health Inspector,
PHL Periye, Periye, Kasaragod Distt, Kerala.

Dear Sir,

I found the issue of NRHM Newsletter Vol. 3 No. 3 Sept Oct very interesting. The article on the girl child (Care for your daughter) was really informative and thought provoking. Though the GOI is doing its best to save the girl child it is only the moral responsibility of every citizen of this country to really understand this issue and support the govt. efforts whole-heartedly. I would be very happy and thankful to you if you include me in the mailing list. Please do send me the previous issues so that it can be kep in our departmental library for staff and students use.

DR. E. Ravi Kiran, MD,
Professor of Community Medicine,
Konaseema Institute of Medical Sciences,
Chaitanya Nagar, NH 214,
Amalapuram 533 201, East Godavari Distt.
Andhra Pradesh.

Dear Sir,

I am working as a general practitioner in rural areas since last 7 years. Your newsletter is very useful at primary care level. Kindly send the same and also enroll my name in your mailing list.

Shri J. Veeresh,
H.No. 3-128, Holagunda Post, Alur TQ,
Kurnool Distt. 518 346
Andhra Pradesh

Dear Sir,

Just by my good luck, I got an opportunity to read NRHM of Sept-Oct. and found information on Leprosy and Homoeopathy very convincing, concise and up to date. Please send me English and Hindi version regularly. I am well versed with NRHM activities. It is like N for Nanak, R for Ram, H for Hazarat Paigamber and M for Mother Mary to Rural India.

Dr. A.M. Mathesul, MBBS,
Behind Dattas Temple, Opp. Stella Mary School,
Wedgaon Sheri, Pune 14

Dear Sir,

I am working as O&G Consultant in Community Health Centre, Naktideul, Distt. Sambalpur, Orissa. I found this newsletter very informative. Kindly include our name in your mailing list.

Medical Officer,
Office of the Medical Officer, Naktideul,
CHC, Naktideul.

NRHM has boosted immunization coverage

Dear Sir,
Recently I have read the NRHM booklet edited by you. It is my pleasure to read the booklet. I am a DNB Pediatrics trainee doctor. As the NRHM programme involves a lot of pediatric component also, it is of specific interest for me.
I will be thankful if you can send recent edition of the booklet to our library. I am attached to Sassoon General Hospitals and B J Medical College, Sassoon Road, Pune, Maharashtra.

Dr Mangesh Khandave
Sassoon General Hospital & B.J. Medical College,
Sassoon Road, Pune (Maharashtra)

Dear Sir,

I could find that the NRHM Newsletter is enriched with a lot of good information. It is my sincere hope that you would include article on integration of AYUSH Doctor especially from Ayurveda. Nowadays Ayurveda is a highly economically viable system of medicine that be easily integrated into the Primary Health Care system in India. Kindly send me a copy of your Newsletter regularly.

Dr. Dilip Kumar Kundu,
Senior Ayurvedic Medical Officer,
State Ayurvedic Dispensary,
Barjora, Bankura, West Bengal.

Dear Sir,

Hearty greetings from SADBHABANA. Sadbhabana is a state level NGO working in the field of family health, welfare, youth development, rural development, trainings etc. and also running a Library where readers regularly visit and read various magazines, Newsletters and various books. Kindly include our name in your mailing list.

SADBHABANA,
Karati Lane, Dolamandap Sahi
Puri 752 001, Orissa.

Dear Sir,

I read your Newsletter regularly. The NRHM Newsletter is very resourceful and useful for us. The contents of the Newsletter are very informative and have tops for practical usage in the field. Kindly send me the NRHM Newsletter (English version) on regular basis.

Dr. Vikas W. Vinchurkar,
Rural Hospital Chikhaldaris,
Tq. Chikhaldaris, Distt. Amravati,
Maharashtra., Tamil Nadu

Dear Sir,

I am working as Health Inspector in Padukkapattu, Govt. Primary Health Centre, Thoothukudi Distt., Tamil Nadu. I have ready your NRHM Newsletter Sept.-Oct. In this edition, leprosy was explained clearly and also very useful to the public as well as the staff of the Health Department. Like this, I would suggest to publish the various diseases in every edition. I request you to kindly send the Newsletter every edition.

Shri R. Ponmuthu Unanasekar,
Health Inspector,
Govt. Primary Health Centre,
Padukkapathu, Thoothukudi Distt. 628 703
Tamil Nadu

Dear Sir,

We happened to receive a copy of your NRHM Newsletter. If is very informative and our readers are interested to get a copy for our Library which situates far flung in the Arabian sea. I shall feel highly obliged if you arrange to include us in your mailing list.

Library & Information Assistant,
Public Library, AMINI Island,
Union Territory of Lakshadweep 682 552

Dear Sir,

I would be highly obliged if you kindly arrange to enroll my name in your mailing list for sending me a copy of NRHM Newsletter regularly and also the previous issues of Newsletter which really contain the updated information about the ongoing public health activities.

Dr. Ramendra Nath Pramanik,
DC-8/3, Shastribagan, Baguiati,
P.O. Deshbandhunagar, Kolkata 700 059.

Dear Sir,

I read your Newsletter regularly and found the same very informative. Kindly send me English edition of the Newsletter regularly at my clinic address.

DR.K.N. Nawal,
S/o DR. K.N.Yadav,
KAN Hospital.
Dharmshala Road, Pratapganj.
PO- Pratapganj, Distt. Supal - 852125, BIHAR

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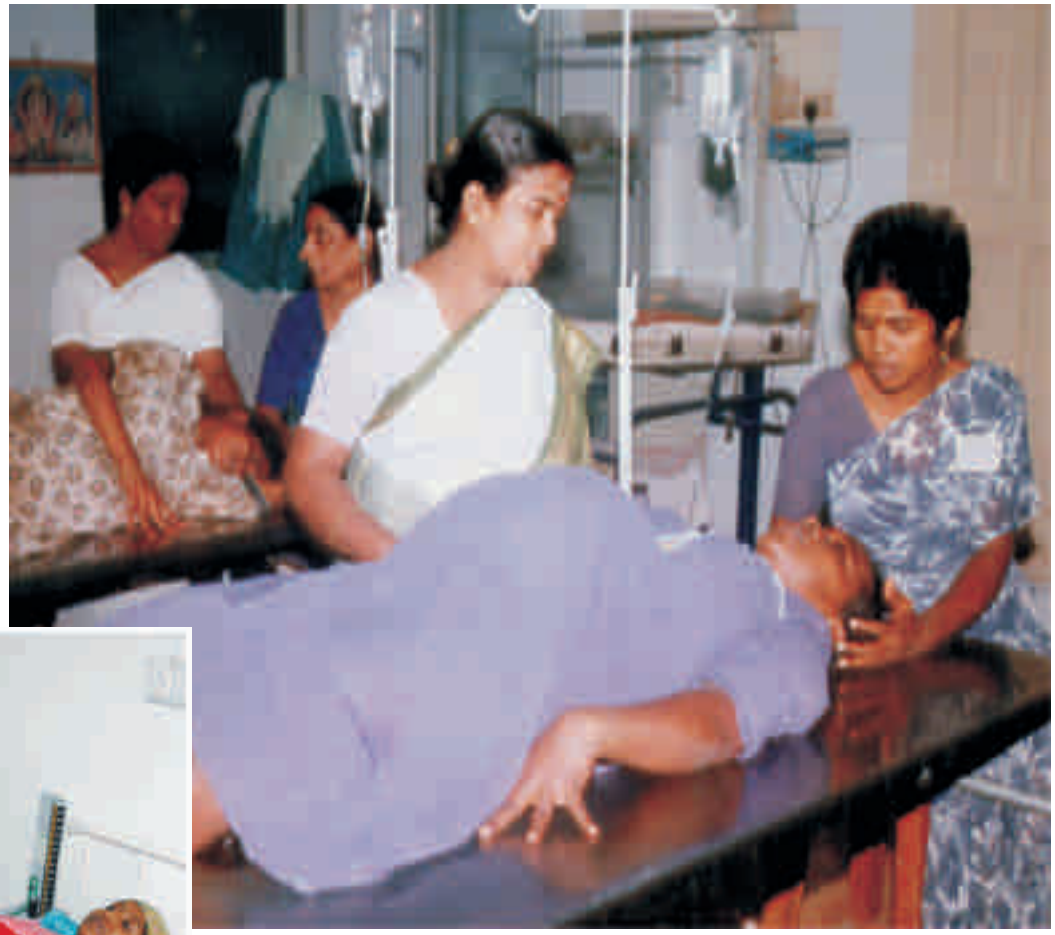
Make Mother & Baby Safe

Path to *Safe delivery*

- Register Pregnancy in a Hospital/Health Centre
- At least 3 check-ups must during pregnancy
- Take TT Immunization, Iron & Folic Acid tablets
- Opt for delivery only at hospital or by a Skilled Birth Attendant
- 2 check-ups after delivery Check-up within 48 hours Of delivery will ensure Survival of baby too



Impact of sustained campaigns

Antenatal care services expanded

Hospital deliveries increased

More Safe deliveries by doctors, staff nurses/ ANM

Marked rise in Immunization programme for mother and children

Immunization facilities available at all Anganwadi Centres, Health Sub Centres, Primary Health Centres, Community Health Centres, District Hospitals and major hospitals.

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Nearly 123 lakh families already benefited from hospital delivery under Janani Suraksha Yojana